

STRATEGY
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**PULLING OUT OF A TAILSPIN:
REBUILDING THE DENTAL CORPS AFTER DOWNSIZING**

BY

**COLONEL LARRY R. CAMP
United States Army**

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ABSTRACT

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The Federal Dental Services have downsized commensurate with the active duty forces which they support. This downsizing has masked, and arguably exacerbated serious problems with recruiting and retaining dental officers. The Services find themselves short of military dentists in an environment which promises to only worsen without prompt, effective action on the part of the Department of Defense (DoD) and/or Congress. This paper examines the dental role in military readiness. Further, it documents the decline of retention and recruiting within the Services and relates the decline to deterioration of a competitive pay structure. Additionally, the paper proposes changes to Dental Special Pay structure and recruiting incentives designed to restore the Dental Corps as a viable career option for dentists again.

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One of seven members of the armed forces are non-deployable because of a serious dental condition. Nine out of ten service members have untreated dental needs including cleanings, fillings or other treatment.¹ In addition to affecting readiness, dental care affects quality of life. A recent symposium at Fort Hood, Texas, identified the lack of access to dental care as the number one health concern of soldiers. In an effort to address this concern, Pentagon officials have shifted \$75 million in an emergency stopgap move to hire contract dentists to compensate for the shortfall of military dentists in FY97.² How did this situation develop and what can be done to again restore the Federal Dental Services to a sustainable entity? This paper will examine the implications of dental readiness for the military, examine the shortage of military dental personnel, which is the underlying cause creating the current situation, and make projections for future Federal Dental Services. This paper will conclude with several proposals to restore the Federal Dental Services to viable organizations again.

The Dental Role

The end of the Cold War has necessitated a change in our National Security Strategy. The U. S. strategy of engagement and enlargement combined with a reduced military force structure has resulted in an increased operational tempo (OPTEMPO) and deployment of United States forces worldwide. The escalating frequency of these deployments, combined with limited availability and capability of dental care at these overseas deployment sites, makes treatment of pre-existing dental conditions imperative prior to deployment. One lesson learned from Operation Desert Shield/Desert Storm was the importance of dental readiness. Over 150,000 Army National Guard and Reserve soldiers were processed by dental facilities in the United States. Mobilization processing

schedules and dental care resources were severely stressed by the examination and extensive treatment requirements of mobilizing soldiers. Over 33,000 reserve soldiers required dental treatment and over 40,000 required panographic radiographs (x-rays) for personnel and graves registration use in post-mortem identification.³ Current dental manpower, both on active duty and in the reserves, has been reduced to the extent that such an effort would not be possible. Past mobilizations have made it evident that:

- There is little time for dental treatment during mobilization and deployment.
- A high level of predeployment dental readiness greatly reduces deployment dental processing and subsequent treatment time.
- A high level of dental readiness greatly reduces the number of service members who develop dental emergencies while deployed overseas.

The primary means which DOD uses to measure a service member's dental readiness is via the dental fitness classification. Unit commanders use this classification to determine their unit's deployability status and to identify soldiers who require dental treatment prior to deployment. The DOD Dental Classification Guideline contains the following four classes of dental fitness:

- Class 1 - service members who require no dental treatment.
- Class 2 - service members whose existing dental condition is **unlikely** to result in a dental emergency within 12 months
- Class 3 - service members who require dental treatment to correct a dental condition that is **likely** to cause a dental emergency within 12 months
- Class 4 - service members who require a dental examination or panographic radiograph (x-ray)

The number of service members in each dental fitness classification can be used to determine the risk of dental emergencies impacting unit operations. The following table

illustrates the importance of reducing the number of service members in Class 3 to the absolute minimum:

DENTAL FITNESS CLASSIFICATION	RATE OF EMERGENCIES PER 1000 SERVICE MEMBERS PER YEAR ⁴
CLASS 1	67
CLASS 2	145
CLASS 3	530

Although these pre-existing Class 3 conditions may have been present in a service member for months or longer without causing a problem, combat or overseas deployment conditions which combine stress, fatigue and limited diet frequently exacerbate or accelerate the disease processes, and in turn create serious dental emergencies. Successful treatment of these serious dental infections often require the service member to be hospitalized or evacuated. Because of the potential adverse effects on unit readiness, due to noncombat attrition of service members, the Services' goal of dental readiness has been to eliminate Class 3 conditions prior to deployments.

The challenges of meeting that goal and providing dental care for a dynamic population such as the military is difficult enough with full dental staffing. There is a nearly 20 percent turnover of military personnel every year and, according to the 1994 DOD Tri-Service Comprehensive Oral Health Survey, military recruits have more dental needs than the general civilian population. Nearly all recruits (99.3%) need some type of dental work and roughly half fall within dental readiness Class 3. These pre-existing dental problems routinely worsen if left untreated. In fact, much of the current dental effort goes toward bringing the level of recruit's oral health up to dental Class 2. Given the shortages of dental personnel, the time available for routine care is reduced because

dental readiness dictates that treatment priority goes to those service members in dental Class 3 and Class 4.

Without a significant increase in dental assets the DOD goal of 95% dental class 1 and 2 cannot be met. Additionally, service members will continue having problems in accessing services for routine dental care, which could further aggravate dental readiness. Difficulties will also persist for family members stationed in overseas and remote locations who have no reasonable option but to receive dental care at military facilities. Hence, quality of life also suffers.

The Problem

Based on a DOD authorized end strength of 3821 dentists, as of 30 September 1996 there were 3523 dental officers on active duty, a shortfall of 298 officers.⁵ Given the 1999 dental drawdown endstate (3681) and the current dental recruiting and retention situation, it is doubtful that the shortage, now being experienced by DOD, will do anything but worsen. According to DOD (Health Affairs) projections, by 1999 the Services are expected to be 614 (16.7%) officers short of authorization.⁶ Despite a drawdown of over 1000 dental officers, the Services are still unable to meet a declining endstrength target. The fact that dental recruiting goals have not been met for over ten years has thus created unfixable undersized year groups which must absorb an ever-increasing workload. The following (Figure 1) depicts the problem in the Army Dental Corps. The data for the Actual Force Profile is based on years of Active Federal Commissioned Service (AFCS) and number of active duty dentists in the Army as of 30 September 1996.⁷ This profile is compared with an Ideal Force Profile which assumes steady-state accessions and ideal

retention rates. The Ideal Force Profile would allow for the proper mix of grade, specialists, experience, leadership and youth to have a sustainable Dental Corps .

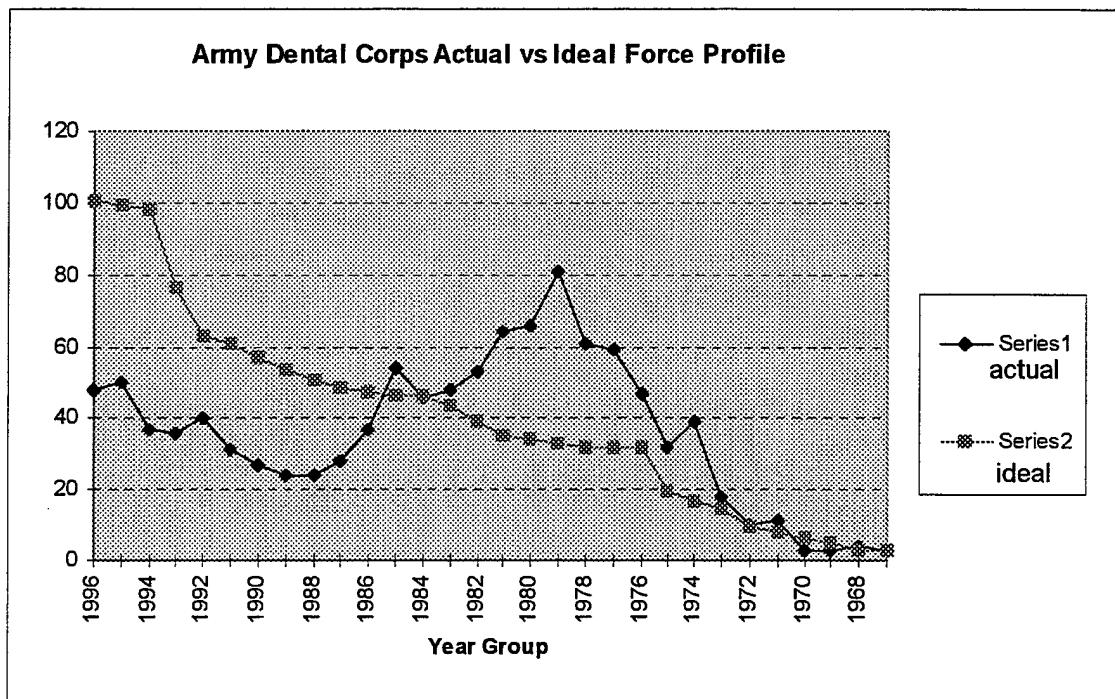


Figure 1.

The above graph clearly shows the problem of undersized year groups which began in 1986. It also shows the relatively large year groups of 1977-1981. The reasons for these larger groups will be discussed later; however, the significance of these large groups is, that within five years, over half of the current Army Dental Corps will be retirement eligible. This fact is more disturbing in an environment of decreasing retention rates and inability to meet dental recruiting accession goals. Considering the large year groups reaching retirement eligibility, declining retention rates, and poor dental recruiting, the immediate future has the potential to deteriorate much more rapidly than anything experienced to date.

The Services' reduced ability to recruit dentists combined with decreasing retention rates of dental personnel, makes endstrength stabilization under current conditions impossible. While many factors have contributed to the military dental personnel shortage, few of these factors fall under the direct control of the Services.

Dental Officer Retention

DOD (Health Affairs) has documented both the decline in recruiting and retention of dental officers since 1986. According to DOD studies the predicted average years of service for dental officers was 12.4 in 1985, by 1988 it had dropped to 10.8 years. Another study in 1994 documented a decline to 8.7 years and in the most recent analysis of 1996 retention data the predicted years of service had declined to 7.4 years.⁸ This decline coupled with current recruiting shortfalls and near term retirement of earlier year groups all point to an eminent "train wreck" of the military dental care system. Effective and prompt action is needed now to change that course.

Efforts have been made in the past to address these issues. Appendix A to the Health Professional Special Pays Study(1989), prepared by the Dental Services, reported the developing trends in military dentistry, and proposed increases in the Dental Variable Special Pay and the addition of a multi-year contract to improve recruiting and retention respectively. This report was forwarded to Congress from DOD (Health Affairs) with a negative recommendation: make no changes in Dental Special Pay. In fact, after completion of the 1995-1996 Retention and Recruitment of DOD Dentists report, DOD (Health Affairs) recommended the elimination of the Dental Accession Bonus and the Board Certification Pay increase portion of the proposed legislation, and did not support

any portion of the proposed legislation for Congressional action. Despite the lack of support from DOD, Congress did pass the original proposed legislation.

More people within DOD and in Congress are now aware of the Services problems in recruitment and retention of dentists. Sound analysis and favorable legislation is now required to remedy the current and future problems of the Federal Dental Services.

Availability of Dentists

To understand how the Federal Dental Services arrived at their current unacceptable state, and more importantly, to predict their future course if aggressive corrective actions are not taken immediately, a review of background information is necessary. In the late 1960's, Congress, acting on reports of severe dental manpower shortages, started Federal Capitation Programs to boost dental school enrollments. This program was quite effective. Some say, too effective. Enrollments soared 50 percent from 1968 to 1978, which led to an overage of dentists and subsequently a halt to the Federal Capitation Programs. However, during the past ten years enrollments have returned to precapitation levels. Besides a decreasing number of graduating dentists from which to recruit, the gender composition of those graduating dentists is also changing (Figure 2). The percentage of graduating female dentists has grown from 1% in 1972 to over 39% in 1995.⁹ This fact is significant in that female dentists have demonstrated the tendency to enter the higher paying civilian sector at a greater rate than their male counterparts.

DENTAL SCHOOL GRADUATES 1986-1996

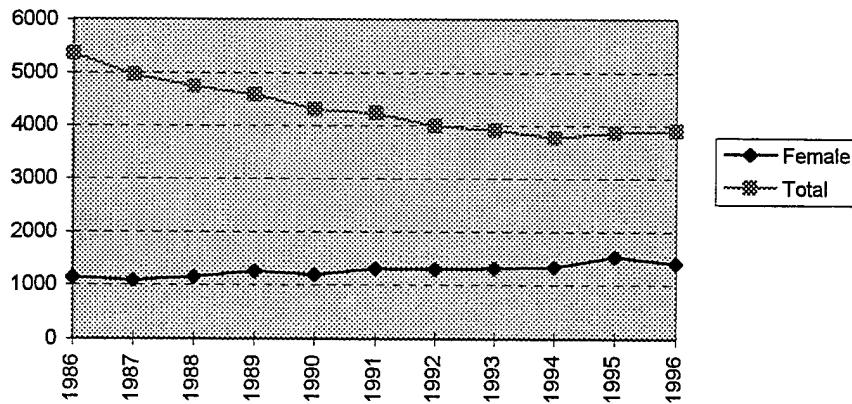


Figure 2.

Minorities dental graduates are also increasing, especially Asian (16%) and Hispanic (8%). However, both groups, like female dentists, have gravitated to the higher paying civilian dental sector

An analysis of the composition of the United States Army Dental Corps, based on 1996 year-end data, reveals the following:

Female and Minority Members

- Female dentists number 105 of 1081 or 9.7%

Female Percentage By Rank	
COL	6 of 244 or 2.5%
LTC	27 of 402 or 6.7%
MAJ	32 of 232 or 13.8%
CPT	35 of 203 or 17.2%

Civilian Counterparts by Graduate Year	
1978	10.6%
1982	15.3%
1988	28.4%
1994	39.5%

- Minority members number 156 of 1081 or 14%

Minority Corps Members by Ethnicity Group		Minority Dental Graduates by Year	
		1986	1994
Asian	- 53 - 4.9%	7%	16%
African	- 81 - 7.6%	3%	4%
Hispanic	- 21 - 1.9%	4%	8%
Native	- 1 - 0.1%	1%	1%

Minority Members by Rank	Minority Dental Graduates by Year
COL - 7%	1978 - 10%
LTC - 12%	1982 - 11%
MAJ - 19%	1988 - 21%
CPT - 24%	1994 - 29%

Yet another recent development in dental school enrollment, which negatively effects the Services ability to recruit, are the number of non-US students attending US dental schools. Starting around 1989 foreign dental school graduates (FDGs) were admitted to US schools as second, third or fourth year dental students. By 1992 nearly 900 (FDGs) were enrolled in 35 of the nations 54 dental schools. The influx of foreign-born dental students is not confined to those entering with advanced standing. In 1993, 38 percent of the applicants to US schools were foreign-born.¹⁰ Foreign dentists graduating from US dental schools further decreases the recruitable population graduating from dental school.

Contractors are also finding it difficult to recruit civilian dentists to fill DOD vacancies resulting from the shortage of active duty military dentists. For example, on 1 December 1996 a contractor for the Army was to have 63 positions filled, but only 47 were filled on time. In January 1997 the same contractor was required to fill 112

positions, yet only 70 were filled.¹¹

The combination of the above trends has had a tremendous impact on the recruitable population and dental services. Based upon current dental school enrollment statistics, there is little prospect for a significant increase in dental graduates for the foreseeable future. The bottom line is that the availability of recruitable dentists is at a historic low point and shows no indication of improvement.

The Effect of Dental Officer Shortages

The shortfall in dental officer strength combined with top-heavy distribution of officers by year group, as depicted earlier in Figure 1, has led to numerous problems beyond the shortage of dental services available to beneficiaries. Sufficient numbers of accessions are needed to: 1) fill positions at all levels of rank and training. 2) allow for attrition of officers who elect to pursue civilian careers. 3) serve as an applicant pool for dental specialty training programs. 4) ensure sufficient officers remain for supervisory and leadership positions.

If accession problems persist, the junior officer population will be less and current shortfalls will prevail. As this problem is not unique to the active duty component, the Reserve Dental Corps cannot be called upon to fill the voids. According to the DOD Health Manpower Personnel Data System Report for fiscal year 1995 only 178 of the authorized 898 O-3 positions had dental officers assigned for the Reserve Dental Corps of all Services, a 20% fill rate.

The impact and consequences of these shortfalls are taking their toll. Workload

and duty requirements have increased. Overseas rotations and Divisional (field) assignments are more frequent, as are deployments and training exercises. More senior officers, by necessity, are filling positions which were once earmarked for junior officers, and additional administrative duties are now being shared by fewer officers. These situations effect morale and have a negative impact on the retention of dental officers. Contract dentists may alleviate some of the dental workload; however, it does not ease the military administrative burden. At an increasing rate, the shortage of general dentists is also causing highly trained specialists to be used for "routine" dental care. The obvious impact is reduced specialty care for patients.

The Changing Nature of Military Dental Practice

A combination of recent events has changed the nature of dental practice in the military. First, the TRICARE Dental Insurance Program combined with the DOD Directive, which severely restricted dental treatment for other than active duty (OTAD), has essentially limited dental practice to active duty patients only. This has had several negative effects. Skills not used or developed in treating a diverse population, embodied in the OTAD population, become atrophied. Treating only a young healthy population deprives the clinician of the opportunity to remain current in treating older medically and dentally compromised patients. The same is true for treatment of developmental conditions encountered in the pediatric patient as well. This situation limits the professional growth opportunity which was once the hallmark of military dental practice.

Additionally, the increased emphasis on dental readiness, combined with dental personnel shortages has focused limited resources on examinations and treatment of

of the patients.

Comparison of Military and Civilian Dental Compensation

Since 1947 special pays have been authorized for medical and dental officers. The authority for these special pays has been to attract and retain the number of health professionals required by the Armed Forces. In the past, whenever the need presented itself, Congress has enacted new special pay initiatives to solve acute problems.

The lack of competitiveness in military Dental Special Pay is at the heart of the acute crisis now facing the military dental services. In the civilian sector dentists are among the most highly compensated of all professionals, especially when consideration is given to the fact that the average dentist only works 34 hours per week. Military dental pay in comparison to civilian sector has declined to its lowest level since the creation of the All-Volunteer-Force (AVF). On average military dentists earn only 44% of their civilian counterparts. This ratio varies based upon years of service and the officer's specialty. Variations also exist depending on the data source for civilian dental income. (The American Dental Association (ADA) income figures are about 20% less than those provided by Dental Economics. ADA figures are used for this paper)

Regardless of the point of comparison the last point of relative competitiveness was 1986. At that time military dental pay was approximately 70% of the civilian pay. Today, generalists in the civilian sector earn approximately two-thirds of the income that dental specialists earn, while in the military, board certified specialists earn slightly more than their generalist colleagues. As an example, a civilian general dentist between 30-34 years old will average \$112,000 net income in 1997. A captain (O-3) in the Dental Corps

than their generalist colleagues. As an example, a civilian general dentist between 30-34 years old will average \$112,000 net income in 1997. A captain (O-3) in the Dental Corps will earn about \$50,000. A civilian dental specialist 35-39 years old averages \$221,000 net income from dental practice compared to a military major (O-4) boarded specialist who earns \$72,000.¹² With these disparities between military and civilian sector incomes it is not surprising that dental recruiting, retention and endstrength have fallen dramatically.

The Military Dental Recruiting Environment

Dental recruiting was not a problem for the military until 1986. The availability of sufficient numbers of Health Professions Scholarship Program (HPSP) scholarships, relatively low graduating debt, large recruitable pool of dental graduates, plus a competitive military pay and retirement system enticed sufficient dentists to enter military service. Additionally, the lure of additional training provided by the readily accessible military Advanced Education in General Dentistry one-year programs provided a good recruiting tool, since civilian programs were not very prevalent at the time.

The enactment of the Defense Officer Personnel Management Act (DOPMA), which became effective 15 September 1981, radically changed the way medical and dental officers were compensated. Four years credit toward pay and retirement was eliminated for those officers commissioned after that date. For a captain (O-3) entering the Dental Corps in 1997 that amounts to a reduction in monthly pay of over \$730/month and for a colonel (O-6) with twenty years of active service the difference is over \$800/month. While medical officers were also affected by DOPMA, the difference was more than offset by increases in Medical Special Pay, which officers in the Dental Corps

did not receive.

Changes in the retirement system in 1981 and again in 1986 further eroded the military compensation benefit for military members. A pre-DOPMA dental O-6 with twenty years active service could retire with 60% of base pay at the twenty-four years of service level, \$3,595/month in 1997. The same O-6 entering active duty in 1986 would retire at 40% of the twenty years of service basic pay, \$2,191/month in 1997. This represents a 39% reduction in retirement pay at twenty years of service. Further, cost of living adjustments are made at a lower level for 1986 officer so the disparity grows after retirement. DOPMA's effect on dental recruiting was not fully felt until 1986. Large raises in military pay in the early 1980's combined with large graduating dental classes, low graduating debt plus a number of delayed pre-DOPMA and HPSP graduates continued to meet the Services need for new accessions.

The disparity in income between civilian and military dentists has become significant since 1986. As previously noted, dental income in the civilian sector has far outpaced inflation while military pay has trailed behind. Dental Special Pay has remained essentially unchanged since 1980, except for a small increase approved by Congress in 1996. A 1995 DOD (Health Affairs) report, Retention and Recruitment of DOD Dentists, stated that in 1986 military dentists with ten years of service earned 68% of what their civilian counterparts earned. By 1994 the percentage had eroded to 49% and by 1997 it is expected to be no better than 44%.

Another problem for dental recruiting and retention has been graduating debt of dentists. Until 1993, the interest on student loans could be deferred for three years upon entering military service. Interest now accrues immediately and the interest paid on

student loans is no longer tax deductible. Graduating dentists' debt has risen from an average of \$37,200 in 1986 to an estimated \$82,500 in 1997.¹³ Payments on a debt of \$82,500 at 8% interest for ten years would be \$1,000 a month. At present Dental Special Pay levels, a dentist entering military service with an average debt would take ten years to retire that debt. Although the recently enacted \$30,000 Dental Accession Bonus provides some relief, it does not significantly reduce the debt burden and permit graduating dentists to enjoy a quality of life comparable to their civilian counterparts. To be more effective, the bonus must be increased.

Another recruiting tool, the Dental HPSP was reinstated in 1990; however, only a limited number were funded. This program has proven to be an effective recruiting tool for the Services, but many more HPSP positions need to be funded to meet present and future requirements for military dentists.

The Need for a New Dental Special Pay Proposal

An analysis of past, current and future dental trends should be performed in designing a new dental special pay proposal. An ever increasing military/civilian pay gap has evolved past the point of competitiveness. Demand for dental services in the private sector continues to drive civilian dental incomes higher -- on average over seven percent annually. The costs of dental education will remain high and graduating dental school debt, already over \$82,500, will continue to be a barrier to military service without increased Dental Accession Bonus funding and increased HPSP Scholarships.

Current and projected dental school graduates will not reverse the declining dentist/population ratio. Dental school enrollments have stabilized with graduation rates

of 4,000 a year expected to continue for the foreseeable future. This number is down dramatically from 6,300 a year in the early 1980's. An additional factor is the changing demographics of those attending dental school. Increased Hispanic, Asian and female dental graduate rates by itself is not a problem. They have been underrepresented in the dental profession in the past. The problem is the Services cannot entice them. This segment of the profession prefers the high paying, highly respected positions in the private sector. An increased foreign-born and foreign dental graduates attending US dental schools also further erode the recruitable population graduating from dental schools.

The All-Volunteer-Force is driven by supply and demand forces. This is especially true in the health service specialties, where skills are acquired in the civilian sector. The military has to remain competitive in the marketplace to provide the personnel needed to staff the force. The Services have had difficulties the past ten years recruiting dentists with the problem becoming more acute in recent years. This chronic problem has led to undersized year groups since 1986.

Retention rates have steadily declined as well. Despite a steep drawdown in the Federal Dental Services endstrength, a shortfall of 298 officers (7.8%) existed at the end of FY96. A large portion of military dentists are approaching retirement eligibility, over 50% of Army Dental Officers within five years. Both retention and recruiting will have to dramatically improve or the current shortages will increase rapidly.

Proposed Enhanced Recruiting Incentives

Enhanced recruiting tools will be needed to reverse past failures in dental recruiting. The Dental HPSP Scholarship has been effective, but not nearly enough have been funded to procure sufficient officers to meet accession requirements. Therefore the

first recommendation would be to increase HPSP funding to meet 90% of projected accession requirements. This step alone will not be sufficient to meet the immediate accession requirements of the Services and will not be felt for 3-5 years, if fully subscribed, because of the time lapse of awarding to graduation. An effective Dental Accession Bonus can fill the void, if sufficiently funded. Currently, no change in the current \$30,000 Dental Accession Bonus is proposed until its effectiveness can be evaluated after one year.

Proposed Enhanced Retention Incentives

The retention part of the dental equation must also be addressed to ensure that an adequate force profile and specialty mix can be achieved. Narrowing the military/civilian pay gap is imperative to reverse the downward spiral of dental retention. As previously noted, general dentists enter military service earning approximately 42% of their civilian counterparts with a pay gap of \$64,000. The gap is even wider with military dental specialists with an O-4 (major) earning about 33% of their civilian specialist counterpart with a pay gap of \$149,000. Clearly, the retention problem will only worsen if this pay gap is not substantially narrowed.

To correct this problem, it is imperative that Dental Special Pay enhancements be enacted now. The following components are proposed to adjust the current Dental Special Pay:

- Variable Special Pay (VSP). Increase the VSP to all dental officers to reduce the disparity between military and civilian income.
- Additional Special Pay (ASP). Increase the ASP to \$15,000 for all dental officers, except those in initial dental residency programs who are ineligible for ASP. The purpose of ASP is to induce dental officers to remain on active duty.

- Board Certified Pay (BCP). No change proposed. Current levels are adequate to encourage dental officers to achieve specialty board certification.
- Incentive Special Pay (ISP) - Specialists only. The establishment of dental specialist ISP in the amount of \$15,000 to improve retention of specialists and encourage general dentists to compete for specialty training. This incentive will narrow the pay gap which is wider with specialists than general dentists.
- Multi-Year Bonus - Specialists only. To establish a long-term retention incentive for dental specialists by the creation of a long-term contract (up to 4 years).

Comparison of Current and Proposed Dental Special Pay In Relation to Civilian Dental Income Comparable Groups

Dentist Type Years of Service	Mil Pay (RMC)	Dental Pay	Total Mil Pay	Civilian Pay#	Pay Gap	Military/Civilian Earning Ratio
Generalist (current)	\$43,000	\$7,000	\$50,000	\$112,000	\$62,000	.45
0-3 Years (proposed)	\$43,000	\$21,000	\$64,000	\$112,000	\$48,000	.57
Generalist (current)	\$56,500	\$13,000	\$69,500	\$145,000	\$75,500	.48
6-8 Years (proposed)	\$56,500	\$27,000	\$83,500	\$145,000	\$61,500	.58
Generalist (current)	\$70,000	\$12,000	\$82,000	\$148,000	\$66,000	.55
12-14 Years (proposed)	\$70,000	\$25,000	\$97,000	\$148,000	\$51,000	.66
Specialist* (current)	\$43,000	\$15,500	\$ 72,000	\$221,000	\$149,000	.33
6-8 Years (proposed)	\$43,000	\$54,500	\$101,000	\$221,000	\$110,000	.50
Specialist (current)	\$56,500	\$16,000	\$ 86,000	\$234,000	\$148,000	.37
12-14 Years (proposed)	\$56,500	\$56,000	\$126,000	\$234,000	\$108,000	.54
Specialist (current)	\$86,000	\$19,000	\$105,000	\$237,000	\$132,000	.44
> 18 Years (proposed)	\$86,000	\$52,000	\$138,000	\$237,000	\$ 99,000	.58

*not all specialists are board certified and not all specialists would take the 4-year contract, but for comparison both are added into the proposed figures

#civilian pay calculated based on ADA 1995 Survey of Dental Practice projected to 1997 assuming 7% annual increase

Dental Special Pay Proposal (Specialists)

Creditable Service	Variable Special Pay		Additional Special Pay		Board Certified Pay		Incentive Special Pay	
	Current	Proposed	Current	Proposed	Current	Proposed	Current	Proposed
0 < 3 years	3,000	6,000	4,000	15,000	2,500	same	none	15,000
3 < 10 years	7,000	12,000	6,000	15,000	2,500	same	none	15,000
10 < 12 years	6,000	12,000	6,000	15,000	3,500	same	none	15,000
12 < 14 years	6,000	10,000	6,000	15,000	4,000	same	none	15,000
14 < 18 years	4,000	8,000	8,000	15,000	5,000	same	none	15,000
> 18 years	3,000	6,000	10,000	15,000	6,000	same	none	15,000
Flag Officers	1,000	6,000	10,000	15,000	6,000	same	none	15,000

Multi-Year Agreement Bonus (Specialists)

2 Year	3 Year	4 Year
\$3,000	\$6,000	\$10,000

Dental Special Pay Proposal (Non-Specialists)

Creditable Service	Variable Special Pay		Additional Special Pay	
	Current	Proposed	Current	Proposed
Interns	3,000	6,000	0	0
O < 3 years	3,000	6,000	4,000	15,000
3 < 10 years	7,000	12,000	6,000	15,000
10 < 12 years	6,000	12,000	6,000	15,000
12 < 14 years	6,000	10,000	6,000	15,000
14 < 18 years	4,000	8,000	8,000	15,000
> 18 years	3,000	6,000	10,000	15,000
Flag Officers	1,000	6,000	10,000	15,000

Conclusion

The present shortage of military dentists threatens to negatively impact the dental readiness and oral health of US military personnel. Returning the Federal Dental Services to a healthy, viable condition after over ten years of accession shortfalls and declining retention rates will be a difficult task. This challenge will be greatly compounded by four major factors: the decreasing availability of recruitable dentists, graduating dental school debts averaging over \$82,500, an increasing disparity between military and civilian dental income, and the increasing numbers of military dentists reaching retirement eligibility during the next five years.

The proposals contained in this paper are necessary, yet only minimally sufficient to improve the current recruiting and retention problems within the Federal Dental Services. The problem of underaccessed year groups (since 1986) cannot be changed at this point and will further express itself in future years in terms of staffing, leadership and professional experience shortages. Leadership and experience shortages cannot be measured in terms of dollars and must not be allowed to increase. Further delays in seriously addressing these problems will negatively impact the oral health of military service members and ultimately impact the readiness of the Army and Armed Forces.

ENDNOTES

¹ Department of Defense (Health Affairs), 1994 Tri-Service Comprehensive Oral Health Report-Active Duty Report, June 1995, NDRI Report No. PR-9503, x.

² Andrew Compart, "Funds shifted to help decaying dental program," Army Times, 7 October 1996, 4.

³ Department of the Army, Military Implications of Dental Disease, GTA 8-9-1. Washington: U.S. Department of the Army, May 1994, 1.

⁴ *Ibid.* 2.

⁵ Dr. John Bircher, analyst, Department of Defense (Health Affairs). telephone interview by author, 28 November 1996.

⁶ *Ibid.*

⁷ Department of the Army, OMF data, 30 September 1996.

⁸ Department of Defense (Health Affairs), Military Dentists Special Pay Study, February 1997, 6.

⁹ American Dental Association, Surveys of Predoctoral Dental Educational Institutions, 1996, 54-56.

¹⁰ Eli Capilouto, "A Review of Methods Used to Project the Future Supply of Dental Personnel and the Future Demand and Need for Dental Services," Journal of Dental Education, Vol. 59, No. 1 (1995):242.

¹¹ MAJ Cronk, DENCOM staff. Interviewed by author, 20 January 1997.

¹² American Dental Association, 1995 Survey of Dental Practice, 1996, 33. Projected to 1997 at a 7% annual increase.

¹³ American Association of Dental Schools, Survey of Dental Seniors 1996 Graduating Class, 1996, 7. Projected to 1997 at a 9% increase.

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